DRAFT-NOT FOR CIRCULATION

THE FUTURE SUPPLY OF LONG-TERM CARE WORKERS IN RELATION TO THE AGING BABY BOOM GENERATION

REPORT TO CONGRESS

September 2, 2002

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This report has been prepared by an interagency workgroup consisting of staff from the Department of Labor's Office of Policy, Office of the Assistant Secretary for Policy and Evaluation, Employment and Training Administration (ETA), Office of Disability Employment Policy (ODEP), Office of Foreign Labor Certification, Bureau of Labor Statistics, and the Department of Health and Human Service's Office of the Assistant Secretary for Planning and Evaluation, Center for Medicare and Medicaid Services (CMS), and Health Resources and Services Administration (HRSA). Staff from the Urban Institute, under contract with the Departments of Labor and Health and Human Services, assisted in the development and writing of this report.

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PREFACE

This report is a product of collaboration between the Departments of Health and Human Services and Labor in response to a request from the U.S. Congress.

In the FY 2002 Senate Appropriation Subcommittee for Labor-HHS Education and the Conference Committee Report for the FY 2002 Labor-HHS Appropriation, Congress requested that the Secretaries of Health and Human Services and Labor identify the causes of the "shortage" of frontline workers (registered and licensed practical nurses, certified nurse aides and other direct care workers) in long-term care settings such as nursing homes, assisted living and home health care; and requested that DOL and HHS make comprehensive recommendations to the respective Committees to address the increasing demand of an aging baby-boomer generation.

To respond to this request, staff at the Departments of Health and Human Services and Labor worked collaboratively to share information and data pertaining to direct care workers in long-term care settings and prioritize and develop a unified set of recommendations for the future. The results of those efforts are presented in this unified report to Congress. In addition, HHS and DOL included information from the following activities:

- HHS held a series of expert meetings focusing on recruitment and retention strategies related to direct care workers in long-term care settings. These topics of these meetings included: (1) extrinsic rewards and incentives (such as wage and fringe benefits), (2) workplace culture (organizational structures, social factors, physical settings, environmental modifications and technology), and (3) expanding labor pools of direct care workers. Participants of these meetings included direct care workers, researchers, State and local policy makers, long-term care providers, and labor economists.

- HHS and DOL staff conducted a review of the research by both Departments on the supply of and demand for direct care workers in long-term settings. DOL maintains industry and occupational employment data through its Occupational Outlook Program. HHS maintains data on the direct care workforce through the National Nursing Survey, and Home and Hospice Care Study.

- HHS and DOL staff conducted a comprehensive review of the research and practice literature related to the shortage of direct care workers in long-term care settings. This included collecting information on surveys of direct care workers, state-sponsored provider surveys, and other estimates of supply and demand of direct care workers in long-term care settings.

EXECUTIVE SUMMARY

One of the challenges facing the U.S. in the 21st century will be to ensure that individuals throughout their life spectrum will be protected and treated with dignity. For the growing population of the elderly and people with disabilities, ensuring the adequacy and availability of direct care workers is a key to meeting this ideal. As this paper shows, the aging "baby boom generation" will be the most significant factor increasing the demand for long-term care services over the next half century. The number of individuals using either nursing facilities, alternative residential care facilities, or home care services is expected to increase from 15 million in 2000 to 27 million in 2050. Most of this increase will be driven by the growth in the elderly in need of such care, which is expected to double from approximately 8 million in 2000 to 19 million in 2050.

In 2000, approximately 1.9 million direct care workers (defined in this report as including registered nurses, licensed practical and vocational nurses, nurse aides, home health and personal care workers) provided care to 15 million Americans in long-term care settings (defined in this report as including nursing and personal care facilities, residential care facilities, and home health care services). BLS estimates that by 2010, direct care worker jobs in long-term care settings should grow by about 800,000 jobs, or roughly 45 percent.[1] Paraprofessional long-term care employment will account for 8 percent of the estimated increase in the nation's jobs for workers in occupations generally requiring only short term on-the-job training.

According to estimates developed by HHS, Office of the Assistant Secretary for Planning and Evaluation (ASPE), after 2010, the demand for direct care workers in long-term care settings becomes even greater as the baby-boomers reach age 85, beginning in 2030. ASPE estimates project the demand for direct care workers to grow to approximately 5.7- 6.5 million workers[2] in 2050, an increase in the current demand for workers of between 3.8 million and 4.6 million (200 percent and 242 percent respectively). This increase in demand will be occurring at a time when the supply of workers who have traditionally filled these jobs remains virtually unchanged.

These projections indicate that it is critical to retain existing long-term care workers and attract new ones. Since many industries will be competing for the supply of workers, pay and working conditions will play a key role in attracting new workers and consequently influencing the supply of long term care services. Providing adequate levels of high quality, compassionate care will require sustained effort by many actors. While the federal government has an important role to play, much of what needs to be

[1] Bureau of Labor Statistics, National Employment Matrix, 2000-2010.

[2] This estimate varies due to different assumptions of the growth rate of home health care.

done will require action on the part of current and new employers who will expand and alter the market itself and shape new solutions. Other solutions will inevitably be crafted by state and local governments, educational institutions, faith-based organizations and providers.

Recommendations

HHS and DOL identified a comprehensive set of recommendation to address potential imbalances between the future demand for and supply of direct care workers in long-term care settings. The recommendations are geared to address key issues relating to:

- compensation, benefits, and career advancement,
- working conditions, job satisfaction,
- finding new sources of workers, and
- the initial and continuing education of workers.

The recommendations include:

National Dialogue With Employers: Engage employers and employee representatives, as well as medical professionals and state and local government, in a dialogue on issues relating to pay, benefits, career ladders, and working conditions in long-term care.

Outreach to Faith and Community-Based Organizations: Explore with faith and community-based organizations their potential role, particularly how they might help increase the number of volunteers for a variety of long-term care needs, such as respite care for family members, assistance to the working disabled, “back-up” services, and home-based support.

Support for State and Local Initiatives: Encourage and support state and local efforts, involving both the private and public sectors. This might include the local “sectoral” approach to support efforts to organize consortiums involving employers, training providers and public agencies to attract new workers, enhance pay and working conditions, and provide both initial, upgrade, and in-service training for long-term care workers.

Regulatory Changes: Explore areas for potential federal and state regulatory changes, which could include enhanced information-sharing and policy-coordination among states, and possible federal record-keeping requirements.

Enhanced Use of Technology in Recruitment, Education, Recording Keeping and Patient Care: Explore use of new technology in recruitment, education, record-keeping and patient care. This could include publicizing the on-line job bank (CareCareers.net).

Support Research Efforts to Inform Policy Makers: Support research and evaluation activities on such subjects as wage, benefits, worker characteristics, workplace cultures.

Enhanced Training and Education: Support multiple initiatives including implementation of the newly passed Nursing Reinvestment Act, efforts to leverage private sector funds similar to DOL's Targeted High Growth Training Initiative, encouraging states to expand the number of slots for training nurses and paraprofessionals, promoting registered apprenticeship training programs for paraprofessional occupations, and others.

New Workers: Seek ways to broaden the supply of workers (e.g., encourage older workers, TANF recipients, other "non-traditional workers including family members and neighbors"). This could be accomplished by disseminating information on long-term health care careers through the Transition Assistance Program (TAP) for military personnel transitioning to civilian life.

Worker Safety: Continue to support worker safety education and outreach to employers, such as through DOL's National Emphasis Program, and through enhanced safety training within schools of nursing and within the paraprofessional training curriculum.

Support Informal Caregivers: Continue efforts to support informal caregivers, such as through tax incentives for caregivers, grants to state and local organizations (e.g. the National Caregiver Support Initiative), providing information and referral resources, and exploring the effectiveness of respite care demonstrations.

INTRODUCTION

One of the challenges facing the U.S. in the 21st century will be to ensure that individuals throughout their life spectrum will be protected and treated with dignity. For the growing population of the elderly and people with disabilities, ensuring the adequacy and availability of direct care workers is a key to meeting this ideal. As this paper shows, the aging "baby boom generation" will be the most significant factor increasing the demand for long-term care services over the next half century. The number of elderly individuals using either nursing facilities, alternative residential care facilities, or home care services is expected to more than double over the next 50 years, increasing from approximately 8 million to 19 million. In large part, this reflects the trend in the number of elderly persons with disabilities, who will have disabling conditions that limit activities of daily living (ADLs), requiring direct care. Similarly, ensuring that people with disabilities have increased opportunities to work and live in the community will generate new demands for direct care workers such as personal assistant services and home health care.

Assuring such care is available will depend in part on there being enough individuals, including paid workers, such as registered and licensed practical nurses, certified nurse aides, personal care attendants, and home health aides, as well as unpaid family members, neighbors and volunteers, to provide the care needed. Many communities are already facing strains in finding a sufficient number of registered and licensed practical nurses and potential shortages in the supply of paraprofessional workers are also occurring in some parts of the country.

But the need is not simply for a sufficient number of workers in long-term care. Such workers need high levels of skills, knowledge, and compassion. This will in turn require high quality initial and continuing training as well as work environments that provide respect and dignity for the workers.

Providing adequate levels of high quality, compassionate care will require sustained effort by many actors. While the federal government has an important role to play, much of what needs to be done will require action on the part of current and new employers who will expand and alter the market itself and shape new solutions. Other solutions will inevitably be crafted by state and local governments, educational institutions, faith-based organizations and providers.

This paper is an attempt to provide a comprehensive view of the potential needs across the full range of occupations in long term care and the supply of available workers. The paper is organized into the following sections:

- **SECTION I**--Provides an overview of the demand for and supply of direct care workers.

- **SECTION II**--Identifies the current and future supply of direct care workers and describes the factors associated with potential imbalances in the supply of the long-term care workforce.

- **SECTION III**--Provides descriptions of HHS and DOL programs and initiatives focused on direct care service workers in long-term care settings; and describes why it is difficult to develop estimates of occupational labor shortages using available data, and then estimates demand for long-term care services in the United States, and provides background on unpaid informal caregivers and paid direct care workers.

- **SECTION IV**--Presents a series of comprehensive recommendations to address the potential imbalance in the supply of and demand for direct care workers in long-term care settings.

- **SECTION V**--Provides additional materials in an Appendix for reference.

I. THE DEMAND FOR AND SUPPLY OF DIRECT CARE WORKERS

A. Overview

The demand for long-term nursing and custodial care--and for the professional and paraprofessional workers to provide it--is driven by the number of Americans in need of long-term care services. While people with disabilities and the elderly both need long-term care services, the most significant factor in the increase for in the demand for long-term care workers over the next half century will be the growth of the elderly population as the baby boom generation ages. The overall number of individuals in need of long-term care will rise from 15 million in 2000 to 26 million in 2050.

In large part, this reflects the trend in the number of elderly persons with ADL limitations that require long-term care services in nursing facilities, alternative residential care facilities, or home care services, which will rise from approximately 8 million in 2000 to over 19 million in 2050.

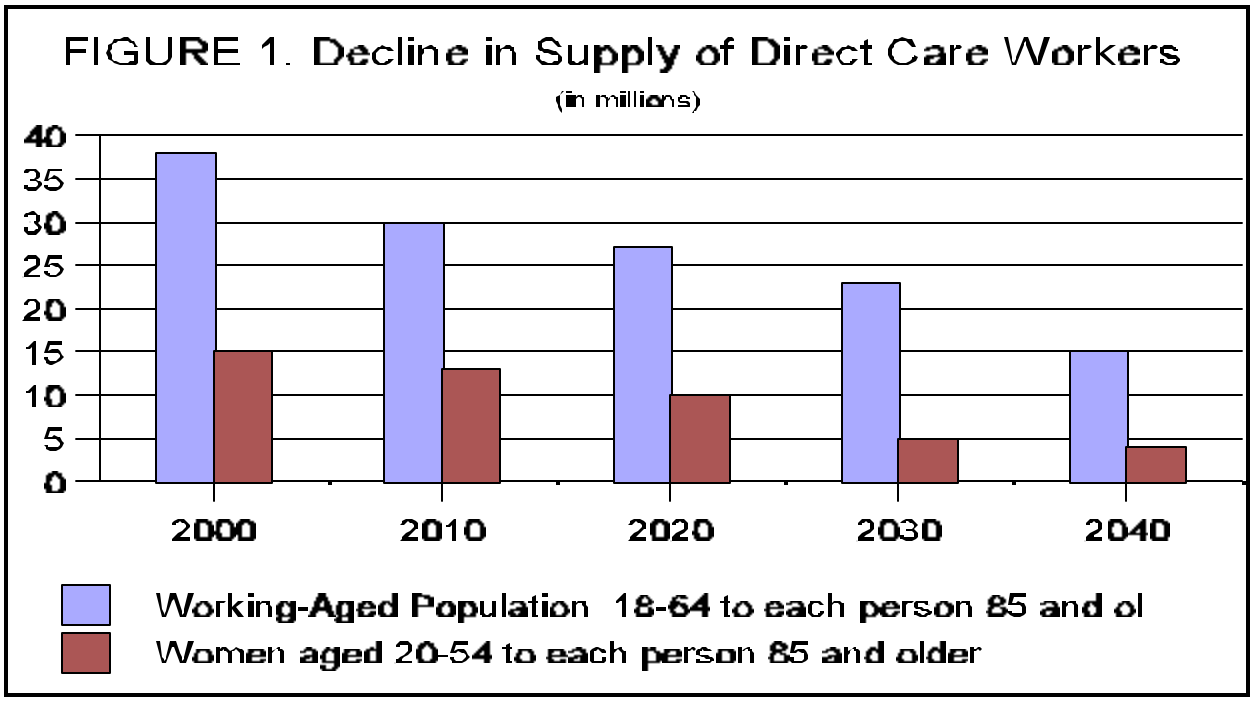
The majority of long-term care services are currently provided by unpaid informal caregivers, primarily family members, neighbors and friends. Informal caregiving will likely continue to be the largest source of direct care as the baby-boom generation retires, with estimates of informal caregivers rising from 20 million in 2000 to 37 million in 2050.

The number of paid workers will also increase dramatically. The Bureau of Labor Statistics (BLS) estimates that if current occupational trends continue, by 2010 direct care worker jobs in long-term care settings (registered nurses, licensed practical and vocational nurses, nurse aides, home health and personal care workers) will likely grow to 2.7 million, an increase of 800,000 jobs or about 45 percent from the 1.9 million jobs these occupations provided in 2000. (See Table 5 and Table 6.) In addition, about 300,000 jobs for direct care workers in long-term care settings will be created due to attrition--defined in this report as the net need to replace workers who leave their jobs permanently to work in another occupation, leave the labor force because of retirement or other reasons, or die. (See Table 7.)

According to estimates developed by the HHS, Office of the Assistant Secretary for Planning and Evaluation, by extrapolating the BLS 2000-2010 projections, after 2010, the potential imbalance becomes even greater especially as the baby-boomers reach age 85, beginning in 2030. By 2050, the estimated number of direct care workers will

range from 5.7-6.5 million workers,[3] an increase of between 200 percent and 242 percent from 2000. (See Table 2.)

There are likely to be considerable challenges in finding an adequate supply of workers in many occupations, particularly since the supply of workers who have traditionally worked in both the paid and unpaid long-term care workforce--women between the ages of 25 and 54 years of age--will only slightly increase. According to BLS, this population group is expected to increase by only 9 percent from 2000 to 2050.[4] Should no sources of new workers be found, the ratio of direct care workers and the population in need of their services may change dramatically, with fewer workers available to care for more individuals.



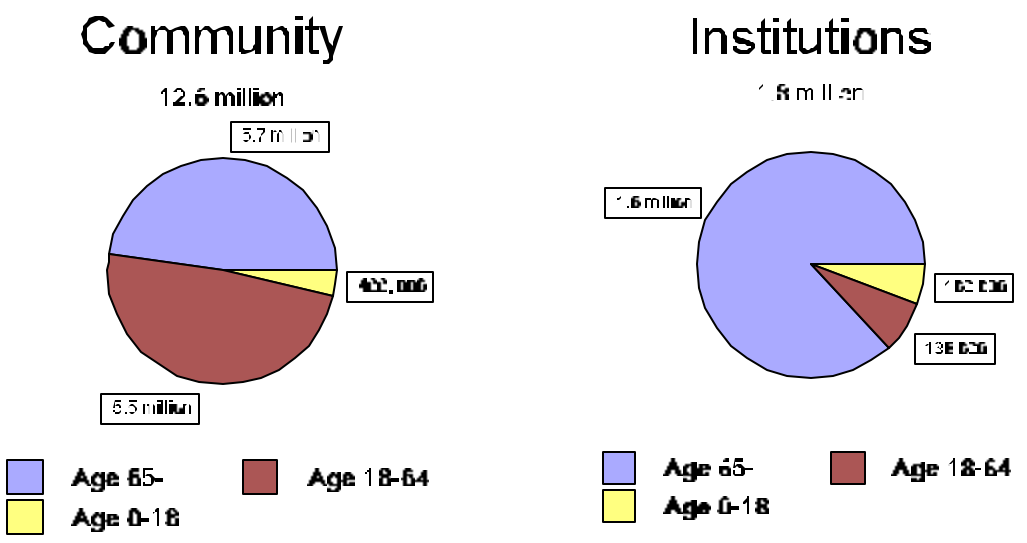
[3] This estimate varies due to different assumptions of the growth rate of home health care.

[4] GAO report on "Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern", May, 2001, GAO-01-750T.

B. Demand for Long-Term Care Services

In 2000, there were 43 million Americans living with a disability. Of these, approximately 13 million Americans need basic assistance with daily activities. This help was provided in a variety of settings, including nursing homes, assisted living facilities, state institutions, home and community-based care settings including board and care homes, adult day care, hospice, group homes, private homes, and other residential service settings. Eleven million Americans receive long-term care services in community-based care settings, and 2 million Americans receive long-term care services in institutional settings.[5]

FIGURE 2. U.S. Population in Need of Long-Term Care Services

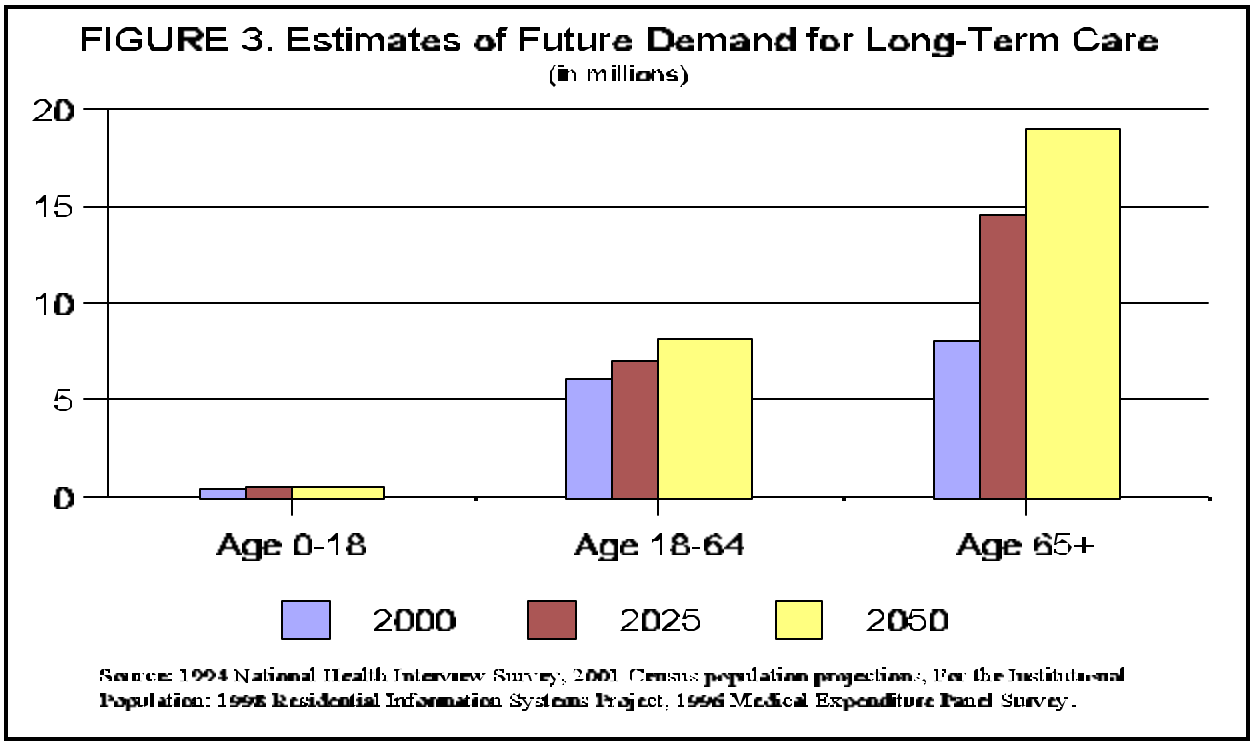


Source: National Health Interview Survey, 1994-5 Disability Supplement, analysis of the Office of the Assistant Secretary for Planning and Evaluation

The future demand for long-term care services is expected to increase for both the elderly and people with disabilities in both institutional and community-based care settings. The decision by the U.S. Supreme Court in the matter of Olmstead v. L.C. requires that services be provided in the most integrated setting appropriate to the individual--which in many cases are home and community-based care settings. As

[5] National Health Interview Survey, 1994-5 Disability Supplement, analysis of the Office of the Assistant Secretary for Planning and Evaluation, 1998).

Figure 3 shows, by the year 2050, it is estimated that 27 million Americans will need long-term care services.[6]



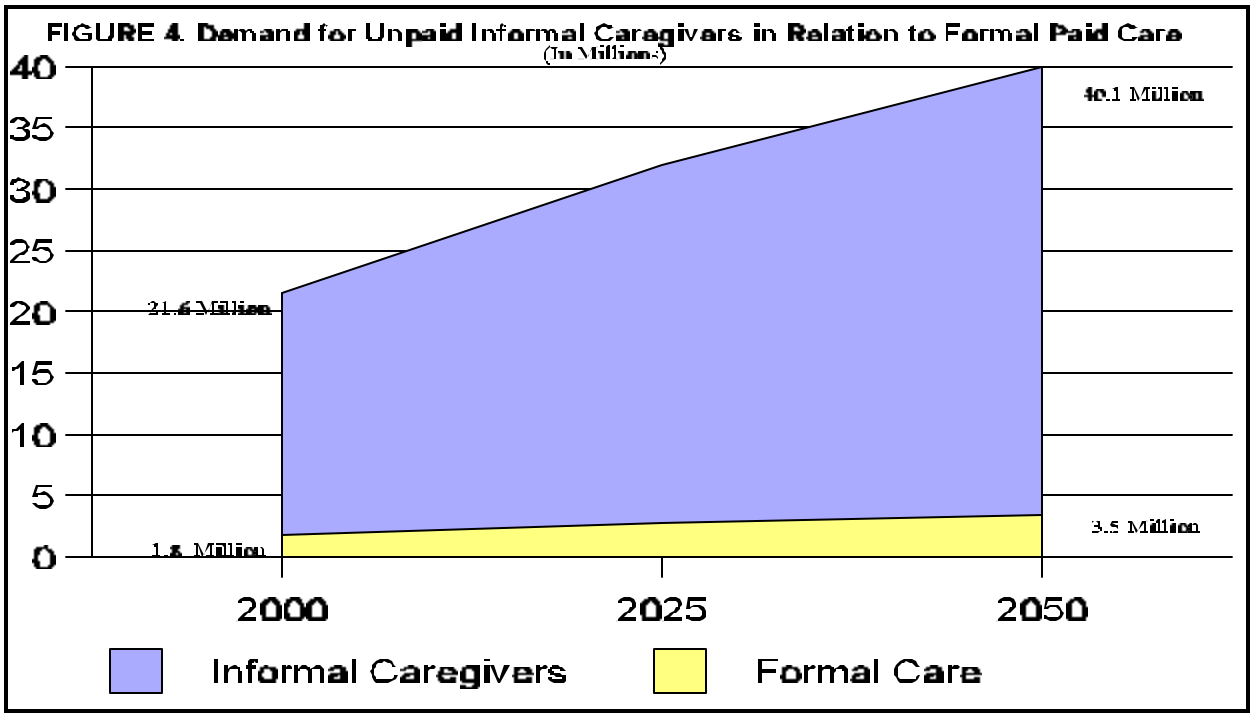
The aging of the baby boom generation will be the most significant factor increasing the demand for long-term care services over the next half century. As illustrated in Figure 3, the number of elderly individuals using either nursing facilities, alternative residential care facilities such as assisted living facilities, or home care services is expected to more than double over the next fifty years, increasing from approximately eight million to 19 million. In large part, this reflects the trend in the number of elderly persons with ADL limitations who require long-term care services. The use of long-term care services will track the aging baby boom generation. The use of long-term care services, and the need for all types of direct care workers in long-term care settings, will increase as the baby boom generation ages: when the baby boom generation starts to reach age 75 in 2021 the use of institutional and home care, and the staff needed to deliver that care, will increase; the number of users will increase even more sharply around 2030 when the baby boom generation starts to reach 85.

[6] Nineteen million aged 65+, 8.2 million aged 18-64, .5 million aged 0-17, estimates developed by the Office of the Assistant Secretary for Planning and Evaluation using the National Health Interview Survey, 1994-1995 Disability Supplement.

C. Informal Caregivers

Critical to understanding the future supply of direct care workers is examining the central role of unpaid informal caregivers in the provision of long-term care, and recognizing the relationship between formal and informal caregivers.

The majority of long-term care services in the United States are provided by informal caregivers. In 2000, there were 20 million unpaid informal caregivers aiding elderly persons in the United States.[7] Using the National Long-Term Care Survey Caregivers Supplement, and the National Health Interview Survey, Figure 4 shows the number of informal caregivers will rise from approximately 20 million individuals caring for approximately 14 million elderly Americans in 2000, to approximately 40 million individuals caring for approximately 28 million Americans in 2050.[8]



[7] Estimates based on rates of informal caregiving, National Health Interview Survey, 1994.

[8] These estimates do not factor in demand or supply variables that may influence the need for informal unpaid care mentioned previously. Estimates are based on data from: National Long-Term Care Survey, 1989 Caregiver Supplement, National Health Interview Survey, 1994.

Demographic factors will undoubtedly bring about some changes in these informal caregiving patterns when the baby boom generation ages and develops long-term care needs. Baby boomers are likely to rely even more on spouses because older husbands and wives are both are living longer and the longevity gap between them is narrowing.[9] However, lower rates of marriage and higher rates of divorce are the distinguishing marital characteristics of this generation, resulting in more boomers moving into middle and older ages without a spouse to help with potential care needs.

Elderly baby boomers will have fewer adult children available to provide informal care because their fertility rate has been lower than that of their parents and because baby boomers are somewhat more likely than earlier generations to be childless.[10] Some adult children may be more likely to seek assistance from paid caregivers because they will have fewer siblings with whom to share the responsibility.

Whether or not these demographic factors will significantly increase demand for paid residential and home care is uncertain, and depends largely on future socio-cultural values, expectations, and preferences.

For example, elderly female baby boomers will, because of their higher labor force participation, have more income and assets than older women of earlier generations. Because of this, many more will likely want to remain in their own homes, alone, at older ages, despite higher levels of disability and this preference can be expected to increase demand for paid home care.

In addition, many attitude surveys already indicate that, when elders become too disabled to live alone safely, many prefer to move into a residential care facility rather than move in with their adult children. This is a significant factor behind the growth of a predominantly private pay market for assisted living facilities over the past 15 years. Finally, studies of private long-term care insurance purchase decisions have found that a major reason why older people buy these policies is to avoid becoming dependent on their children for care. If more baby boomers are motivated to purchase private long-term care insurance over the next 20 years, this is almost certain to stimulate increased demand for paid long-term care--especially at home and in residential alternatives to nursing facilities.

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[9] Easterlin, R.A. (1996), "Economic and Social Implications of Demographic Patterns." In Binstock, R.H. and George, L.K. (eds.), *Handbook of Aging and Social Sciences: Fourth Edition*, Academic Press Inc., San Diego, CA.

[10] Wolf, D.A. (1999), "The Family as Provider of Long-Term Care: Efficiency, Equity, and Externalities." *Journal of Aging and Health*, Vol. 11, No. 3, pp. 360-382.

D. Uncertainty in Long-Term Projections of Demand

Long-term estimates of potential demand for paid direct workers in long-term care settings are influenced by many factors, many which we cannot easily predict:

- There are many factors that could affect the demand for such workers, including the extent and nature of disabilities.

- The availability of informal unpaid caregivers 30-50 years from now depends critically on a number of factors, especially the size and composition of future families, and the limitations of public financing available for long-term care.

- Predicting how nursing homes, assisted living centers, or home health agencies decide to use direct care workers in the future is not clear. Staff ratios may decline as improvements in monitoring technologies and assistive devices allow greater resident independence with ADLs/IADLs, or licensed practical nurses or nurse aide duties may be allowed to delegate much of their current work to new occupational categories of direct care workers, such as single task or universal workers.

- Potentially new forms of long-term care service delivery may evolve in which the demand for or supply of workers may be dramatically altered.

- The extent to which public and private purchasers of long-term care services are willing or able to pay for formal paid direct care workers may effect the supply of the direct care workforce.

- Potential changes in the public and private financing of long-term care workers (personal assistance services, community-attendant care, and home health) and regulation of long-term care settings (nursing home quality standards, potential regulation of assisted living centers, and other residential care providers) may have a dramatic effect on the future balance of supply and demand for direct care workers.

E. Current Number of Paid Direct Care Workers in Long-Term Care

According to the Department of Labor's Bureau of Labor Statistics (BLS), there were an estimated 1.9 million jobs for direct care workers in long-term care settings in 2000. (See Table 5.) These included registered nurses (RN), licensed practical nurses (LPN), licensed vocational nurses (LVNs), nurse practictioners (NP), certified nursing assistants (CNA), nurse aides (NA), orderlies, home health workers, home health aides,

home care aides, personal care attendants, personal care aides, geriatric aides and caregivers.

Of these jobs, about 527,000 were for RNs and LPNs, while approximately 1.3 million were for paraprofessional workers. (See Table 8.) Of the total number of direct care worker jobs in long-term care, 56 percent were in nursing and personal care facilities, 17 percent in assisted living and other residential care settings, and the remaining 27 percent in home health care services.

These occupations include a wide range of education and skill level. Registered nurses are typically college educated, having at least an associate degree. Licensed practical nurses typically complete a one-year post-secondary training program. Nurse aides and other paraprofessionals typically have, at most, some form of on-the-job training.

F. Underestimate of the Number of Current Workers

BLS data exclude some direct care workers in long-term care. BLS data used in this analysis cover wage and salary employment in nursing and personal care facilities, residential care, and home health care services. Wage and salary long-term care jobs for direct care workers employed by hospitals or public agencies and self-employed independent providers are excluded. For this reason, the number of direct care jobs in long-term care is probably underestimated.

Direct employment of long-term care workers by consumers has increased in recent years. For example, a number of states, including California, Washington, Oregon, Michigan, Colorado, Kansas, Maine and Wisconsin, are using consumer-directed home care. In these programs, the individual client is responsible for hiring, training, directing and firing the care worker.[11]

One indication of the size and growth in this self-employed workforce comes from California's In Home Supportive Services (IHSS) program. IHSS pays for in-home supportive services for low-income disabled individuals (over 65, disabled, or blind). Under IHSS, the disabled individual (or individual's family) hires the provider and is considered to be the provider's employer. In California, most of these workers are not captured in the state's Occupational Employment Survey. Over 194,000 Californians

[11] Wiener, Joshua, Tilly, Jane, Alecxih, Lisa Marie, "Home and Community-Based Services in Seven States," *Health Care Financing Review*, 23 (3), 89-114, 2002: Tilly, Jane, Wiener, Josh, "Consumer-Directed Home and Community Services in Eight States: Policy Issues for Older People and Government," *Journal of Aging and Social Policy*, 12(4),: 1-26, 2001.

receive these services monthly, up from 150,000 only seven years earlier.[12] California reports employing 202,000 personal care workers in the IHSS Program. Assuming that there is a roughly one-to-one relationship between the number of clients and the number of workers, another 116,000 workers may be working in public programs in Colorado, Kansas, Maine, Michigan, Wisconsin, and Oregon.[13] Yet, in 2000, the BLS counted only 414,000 personal care workers nationwide.

In addition, direct caregivers who operate as independent contractors and who are not reimbursed by government programs are sometimes paid in cash. Moreover, although required by law to do so, employers often do not pay taxes for these individuals. As a result, there is little information on the size and trends in what is sometimes referred to as the "gray market," direct care workers who are working in a quasi-underground economy and whose labor market activities would not be captured in most formal surveys.

G. Near Term Growth in Employment of Long-Term Care Workers

BLS has developed economic models which systematically project employment by industry and occupation over the period 2000-2010.[14] Using these models, DOL has estimated that:

- There were 1.9 million direct care workers employed in long-term care settings in 2000 (Table 5).
- Employment of direct care workers in long-term care settings in the next 10 years will grow nearly twice as fast as health care employment in general (45 percent vs. 25 percent) and almost three times as fast as eating and dining places (45 percent vs. 18 percent) (Table 6).
- The total number of long-term care jobs for direct care workers will increase by 45 percent or 828,000 between 2000 and 2010 to reach a total of around 2.7 million (Table 6). There will be an increase of 42 percent for professionals (from about

[12] California Department of Social Services (2001). In-Home Supportive Services: Examining Caseload and Costs During State Fiscal Year 1996-99. Sacramento, CA: Department of Social Services, Research and Development Division.

[13] Tilly, Jane, Wiener, Joshua, op.cit.

[14] These models and the resulting projections are contained in the Monthly Labor Review published by the U.S. Department of Labor.

527,000 to 747,000) and 46 percent for paraprofessional long-term care workers (from 1.3 million to 1.9 million) (Table 8).

- About 300,000 jobs for direct care workers will need to be replaced in long-term care settings due to net replacement needs (Table 7). Added to the increase of 828,000 in jobs stemming for occupational employment growth, a total of 1.1 million new jobs will be created due to growth and net replacement needs.

- Twenty-six percent additional direct care worker jobs will be created in nursing home and personal care facilities, and 69 percent additional direct care worker jobs will be created in residential care and home health care settings (Table 9).

- The largest number of job openings due to occupational employment growth for direct care workers will be created among the lowest skilled paraprofessional workers in residential and home health care settings (Table 9).

These projections imply continued rapid growth in the employment of direct care workers in long-term care settings; however, the overall supply of these workers will grow much less rapidly. For this reason, an increasing share of the available labor force will have to be allocated to the long-term care industry.

Increases will be dramatic for low-wage, low-skilled workers. Of the 53 million jobs in the U.S. that BLS classifies as being in occupations generally requiring short on-the-job training, about 2.5 percent are in long-term care. Over the period 2000-2010, the total number of jobs due to growth in these relatively low-skilled occupations is expected to increase by 7.7 million. Eight percent, or about 609,000 of these additional jobs will be in long-term care, a significant shift in the employment of low-wage, low skilled workers.

H. Long-Term Projections of the Labor Force and the Demand for Direct Care Workers (Labor Force) and the Demand for Direct Care Workers

DOL does not provide industry projections beyond 2010, but the Bureau of Labor Statistics has produced labor force projections to 2050. As Table 1 shows below, labor force growth will slow dramatically in the future, with 1.1 percent annual growth over the period 2000-2010, falling to 0.4 percent growth over 2010-2025, then rising slightly to 0.6 percent growth over 2025-2050. This growth reflects the large impact of retiring baby boomers.

TABLE 1. Labor Supply						
	1980	**1990**	**2000**	**2010**	**2025**	**2050**
Labor Force (millions)	107.0	125.9	140.9	157.7	166.6	191.8
		1980-1990	**1990-2000**	**2000-2010**	**2010-2025**	**2025-2050**
Growth Rate (annual)		1.6%	1.1%	1.1%	0.4%	0.6%

The size and composition of the labor force is the principal determinant of overall economic growth. Demand for goods and services in each industry will change over time as consumer preferences and other factors change. However, given a relatively fixed supply of labor, employers in the various industries will compete with one another for the workers. If employment for a particular industry grows much faster than the overall supply of labor, it can only do so by taking workers away from employers in other industries.

BLS employment projections estimate that employment of direct care workers (RNs, LPNs, and aides) is expected to grow at 2.3 percent in nursing homes, 5.5 percent in home health, and 5.2 percent in residential care per year over the period of 2000-2010. Each of these employment growth rates is much greater than the anticipated 1.1 percent growth in the labor force. Even if long term care employers were to meet the 2010 employment projections these growth rates would be difficult to sustain beyond 2010 because labor force growth will slow further.

Data in Table 2 show the implications if the BLS growth rates were to persist to 2050, as estimated by HHS. In 2000 there were 77 persons in the labor force for each long-term care job. By 2010 BLS estimates that this figure will decrease to 60 persons per job. By 2050 HHS estimates that there would be 14 persons per long-term care job.

TABLE 2. Direct Care Workers Projections--Scenario 1 (2000-2010 Growth Rates)							
Industry (millions of workers)	2000	2010	2025	2050	Assumed Growth Rates		
					2000-2010	2010-2025	2025-2050
Nursing Homes and Personal Care	1.04	1.31	1.84	3.26	2.31%	2.31%	2.31%
Home Health	0.47	0.80	1.78	6.74	5.46%	5.46%	5.46%
Residential Care	0.31	0.52	1.11	3.99	5.24%	5.24%	5.24%
Total Long-Term Care	1.82	2.63	4.74	13.99			
% Labor Force in Long-Term Care	1.3%	1.7%	2.8%	7.3%			

The growth rates BLS that uses for the projections to 2010 are heavily influenced by the historical growth in long term care employment. The1990s were an unusual time in two major respects. Medicare spending for home health and skilled nursing facility care increased dramatically until 1998. In addition, elderly persons began to view assisted living facilities as desirable places to live, and as possible alternatives to nursing home care. It is unlikely that the historical growth rates in these industries can be maintained in the future.

A more realistic scenario, as shown in Table 3, is that the growth rate in home health and residential care industry would taper off after 2010, and perhaps before. Holding the home health and residential care growth rates at the 2.3 percent level assumed for the nursing and personal care home industry, results in an increase in the employment of direct care workers in the long-term care industry from 1.8 million in 2000 to 6.6 million in 2050. However, this reduced scenario still requires substantial shifts of workers to the long term care industry. In 2000 there were 77 persons in the labor force for each long-term care job. By 2050 HHS estimates that there would be 29 persons per long-term care job.

TABLE 3. Direct Care Workers Projections--Scenario 2 (2000-2010 Growth Rates Tapered)							
Industry (millions of workers)	2000	2010	2025	2050	Assumed Growth Rates		
					2000-2010	2010-2025	2025-2050
Nursing Homes and Personal Care	1.04	1.31	1.84	3.26	2.31%	2.31%	2.31%
Home Health	0.47	0.80	1.13	2.01	5.46%	2.31%	2.31%
Residential Care	0.31	0.52	0.73	1.29	5.24%	2.31%	2.31%
Total Long-Term Care	1.82	2.63	3.70	6.56			
% Labor Force in Long-Term Care	1.3%	1.7%	2.2%	3.4%			

Another scenario, as seen in Table 4, further assumes that the impact of the Balanced Budget Act of 1997 and related Medicare legislation on the home health home industry results in no employment growth from 2000 to 2010, and then growth of 2.3 percent from 2010 to 2050. This would have a slight effect on the projections in the long run, reducing the number of long-term care jobs in 2050 from 6.6 million to 5.7 million. HHS estimates that there would be 34 persons per long-term care job in 2050.

TABLE 4. Direct Care Workers Projections--Scenario 3 (2000-2010 Growth Rates Tapered + Home Health Reduced)							
Industry (millions of workers)	2000	2010	2025	2050	Assumed Growth Rates		
					2000-2010	2010-2025	2025-2050
Nursing Homes and Personal Care	1.04	1.31	1.84	3.26	2.31%	2.31%	2.31%
Home Health	0.47	0.47	0.67	1.18	0.00%	2.31%	2.31%
Residential Care	0.31	0.52	0.73	1.29	5.24%	2.31%	2.31%
Total Long-Term Care	1.82	2.30	3.24	5.73			
% Labor Force in Long-Term Care	1.3%	1.5%	1.9%	3.0%			

These projections do not account for unforeseen changes in the future labor market, such as relative strength or weakness of national and local economies, which may be a factor in the future employment in long-term care settings. Similarly, changes in federal training and education programs, scholarship and loan programs, and immigration policy may have a significant impact on the supply of direct care workers.

Table 5. Employment of Direct Care Workers in Long-Term Care Settings, 2000 and Projected 2010

	2000 Employment		Projected 2010		Change 2000-2010	
	Number	% of Industry	Number	% of Industry	Number	%
Nursing and Personal Care Facilities	1,038,000	58 %	1,305,000	60%	267,000	26%
Nursing Aides, Orderlies and Attendants	644,871	35.9%	797,483	36.4%	152,611	23.7%
Licensed Practical and Vocational Nurses	202,604	11.3%	248,179	11.3%	45,575	22.5%
Registered Nurses	144,112	8%	196,038	9%	51,926	36%
Home Health Aides	33,606	1.9%	41,559	1.9%	7,953	23.7%
Personal and Home Care Aides	13,256	.7%	22,130	1%	8,875	66.9%
Residential Care	310,910	38.6%	518,013	39.3%	207,102	66.6%
Home Health Aides	130,700	16.2%	200,175	15.2%	69,475	53.2%
Personal and Home Care Aides	92,198	11.4%	172,586	13.1%	80,388	87.2%
Nursing Aides, Orderlies and Attendants	54,559	6.8%	92,845	7%	38,286	70.2%
Licensed Practical and Vocational Nurses	17,599	2.2%	25,428	1.9%	7,828	44.5%
Registered Nurses	15,854	2%	26,979	2.1%	11,125	70.2%
Home Health Care Services	505,111	74.2%	859,457	75.4%	354,345	70.2%
Home Health Aides	191,949	29.9%	326,606	30.2%	134,657	70.2%
Personal and Home Care Aides	132,979	20.7%	226,266	21%	93,287	70.2%
Registered Nurses	104,141	16.2%	177,199	16.4%	73,057	70.2%
Licensed Practical and Vocational Nurses	43,150	6.7%	73,421	6.8%	30,271	70.2%
Nursing and Psychiatric Aides[1]	32,892	.7%	55,965	1%	23,073	70.1%

Source: Bureau of Labor Statistics, National Employment Matrix, 2000-2010

1. Estimates include psychiatric aides, separate data on nursing aides are not available, due to confidentiality restrictions. Note: BLS data excludes some direct care workers in long-term care. BLS data used in this analysis cover wage and salary employment in nursing and personal care facilities, residential care, and home health care services. Wage and salary long-term care jobs for direct care workers employed by hospitals or public agencies and self-employed indepedent providers are excluded.

Table 6. Employment Growth in Selected Occupational Groupings and Industries, 2000 and Projected 2010			
	2000	2010	Percent Change
Direct Care Workers in Long-Term Care Settings	1,854,000	2,683,000	45%
Health Services Sector	11,065,00	13,882,000	25%
Eating and Drinking Places	8,114,000	9,600,000	18%

Table 7. Net Replacement Needs for Direct Care Workers, 2000-2010[1]			
	Total Employment in LTC Settings	Annual Average Attrition Rate	Net Replacement Needs, 2000-2010
Registered Nurses	264,000	2.0%	53,000
Licensed Practical and Vocational Nurses	263,353	2.6	68,472
Home Health Aides	356,255	1.3	46,313
Nursing Aides, Orderlies, and Attendants	732,332	1.3	95,202
Personal and Home Care Aides	238,433	1.5	35,765

1. These calculations assume long-term care industry rates are identical to the average rate across all industries for each occupation. Attrition, as defined in this report, is the net need to replace workers who leave their jobs permanently to work in another occupation, leave the labor force because of retirement or other reasons, or die.

Table 8. Employment of Professional and Paraprofessional Direct Care Workers in LTC Settings, 2000 and Projected 2010			
	2000	2010	Percentage Increase
Professional (Registered Nurse, Licensed Practical and Vocational Nurse)	527,000	747,000	42%
Paraprofessional Direct Care Workers (Home health aides, personal and home care aides, nursing aides, orderlies, and attendants)	1,327,000	1,936,000	46%

Table 9. Employment of Professional and Paraprofessional Direct Care Workers by LTC Setting, 2000 and Projected 2010			
	2000	**2010**	**Percent Change**
Professional in Nursing and Personal Care Facilities	347,000	444,000	28%
Paraprofessional in Nursing and Personal Care Facilities	692,000	861,000	25%
Professional in Residential and Home Health Care Settings	181,000	303,000	68%
Paraprofessional in Residential and Home Health Care Settings	635,000	1,074,000	69%

Table 10. Wages for Registered Nurses in Long-Term Care Settings, 2000		
Setting	**Employment**	**Median Wage**
Nursing and Personal Care Facilities	146,000	$19.87
Hospitals, Public and Private	1,272,320	22.01
Home Health Care Services.	112,800	20.98
Residential Care	16,210	18.67

II. IMBALANCES IN SUPPLY OF AND DEMAND FOR SPECIFIC OCCUPATIONAL CATEGORIES OF THE LONG-TERM CARE WORKFORCE

Below we have identified factors contributing to potential imbalances in the supply of and demand for direct care workers in the future. Direct care workers such as: therapy aides, rehabilitation aides, employment support aides, medication aides and other paraprofessional long-term care workers are not included in this discussion because we were unable to identify enough literature or survey research to meaningfully discuss the scope of the potential labor imbalances for workers in these categories. We have structured the analysis around the occupational categories of workers tracked by the U.S. Bureau of Labor Statistic's survey of employers: (a) registered nurses, (b) licensed practical nurses, (c) nursing aides, orderlies and attendants, (d) home health aides, and (e) personal and home care aides. Direct care workers include both professionals and non-professionals or "paraprofessionals".

A. Professional Direct Service Workers

Registered nurses (RNs) and licensed practical nurses (LPNs) represent approximately 28 percent (527,000) of direct care workers in long-term care settings. Their responsibilities in nursing homes and personal care facilities include direct patient care and supervision of paraprofessional direct care staff. Registered nurses have the most education, and are subject to state licensing requirements. Licensed practical and vocational nurses must also obtain state licensure, and receive education through formal training programs, typically one year in length.

1. Registered Nurses

RNs represent approximately 14 percent (264,000) of direct care workers in long-term care settings such as nursing and personal care facilities, and residential and home health care settings.[15] A slight majority, 54 percent (144,000) of long-term care registered nurses are employed in nursing and personal care facilities settings, compared to residential and home health settings. Their roles in both institutional settings include direct patient care, supervision of LPNs and CNAs, and management of paraprofessional direct care staff. In residential settings, RNs provide nursing care in a patient's home and supervise LPNs and other paraprofessional staff.

[15] Bureau of Labor Statistics, National Employment Matrix, 2000-2010.

The Bureau of Labor Statistics (BLS) estimates that registered nurses held 264,000 jobs in 2000 in nursing homes, personal care facilities, residential care, and home health care services settings.[16, 17] The BLS estimates over the period from 2000 to 2010 that 136,000 new jobs for RNs in long-term care settings will be created due to increasing demand for services. In addition to occupational employment growth, 53,000 job openings will result from the need to replace registered nurses who leave the occupation permanently to enter other jobs, retire, or leave the labor force for other reasons.

Several factors may be combining to constrain the current and future supply of registered nurses in all health settings including:

- The decreasing number of nurses in the training pipeline and shrinking pools of new workers able to replace those nurses who are leaving or retiring from nursing.[18, 19]
- The training it takes before new nursing students complete their education and can enter the labor market.[20]
- The shortage of nursing faculty available to teach new nurses.
- The decreasing retention of nurses in the profession due to decreased job satisfaction--40 percent of nurses are dissatisfied with their jobs.[21]
- A recent ANA survey reveals the aging of the nursing workforce: 66 percent of all nurses surveyed are 41-60 years older.

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[16] Ibid.

[17] This number does not include registered nurses who worked in hospital-based post-acute long-term care.

[18] HRSA, The Registered Nurse Population: National Sample Survey of Registered Nurses, March, 2000.

[19] Data from the National League of Nursing show that there was only a 10 percent increas in graduates from RN education programs between the 1975-6 and 1997-8 academic years (Levine, Linda, Specialist in Labor Economics Domestic Social Policy Division. A Shortage of Registered Nurses: Is It On the Horizon or Already Here. In CRS Report for Congress. Congressional Research Service, pp. 1-20, May, 2001.

[20] Salsberg, Edward, "Assuring an Adequate Supply of Health Workers To Provide High Quality Care to America's Seniors," January, 2002.

[21] ANA, 2001 (get full citation).

Specific additional factors contributing to the shortage of registered nurses in long-term care settings include:

- The lower salaries of registered nurses in long-term settings as compared to registered nurses in hospital settings--in 2000 the median hourly wage for RNs in hospital settings was 18 percent higher than for RNs in residential care settings ($22.01 versus $18.67).[22]

- Lack of authority nurses have to hire direct care staff.

- The complex regulatory environment in nursing homes creating paperwork and taking nurses away from providing care.

- Professional isolation of nurses in long-term care positions.

- Lack of benefits compared to nurses in other practice settings (health care, transportation, fringe).

- The higher turnover rate of RNs and LPNs in nursing home chains than in acute care settings.[23]

2. Licensed Practical and Licensed Vocational Nurses[24]

LPNs represent approximately 14 percent (263,000) of direct care workers in long-term care settings.[25] LPNs provide basic bedside care under the direction of RNs or physicians. Their roles in long-term care settings include direct patient care (assistance with ADLs and IADLs), and administering prescription drugs. In nursing homes, LPNs take on additional roles such as: developing care plans, and supervising the activities of nurse aides, home health aides, and personal care workers. In residential settings, LPNs take on additional roles such as: teaching family members nursing tasks, and supervising home health and home care aides.

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[22] Bureau of Labor Statistics, Occupational Employment Statistics Survey, 2000.

[23] Preliminary analysis of a 2001 survey of nursing homes conducted by the American Health Care Association (AHCA) that annualized turnover for nursing facilities were 55.5 percent for RNs, and 51.5 percent for LPNs (American Health Care Association. Preliminary Results of the 2001 AHCA Nursing Position Vacancy and Turnover Survey, Washington, D.C. October, 2001.)

[24] As defined by the BLS, LPNs and LVNs care for ill, injured, convalescent, or disabled persons in hospitals, nursing homes, clinics, private homes, group homes, and similar institutions. They may work under the supervision of a registered nurse, licensing required.

[25] Bureau of Labor Statistics, National Employment Matrix, 2000-2010.

The Bureau of Labor Statistics (BLS) estimates that licensed practical and vocational nurses held 263,000 jobs in 2000 in nursing and personal care facilities, and residential and home care settings.[26] The BLS projects over the period 2000-2010 that 84,000 new jobs for licensed practical and vocational nurses in long-term care settings will be created due to increasing demand for services. In addition to occupational employment growth, 68,000 job openings will result from the need to replace registered licensed practical nurses who leave the occupation permanently to enter other jobs, retire, or leave the labor force for other reasons.

Several factors may be combining to constrain the current and future supply of licensed practical nurses in long-term care settings:

- the decreasing number of LPNs in the training pipeline;
- the shortage of nursing faculty available to teach new LPNs;
- lack of benefits compared to LPNs in other acute care settings; and
- the higher turnover rate (51 percent) of nurses and LPNs in nursing home chains than in acute care settings (AHCA Survey, 1999).

B. Paraprofessional Direct Service Workers

Paraprofessional long-term care workers represent approximately 72 percent (1,327,000) of direct care workers in long-term care settings. These paraprofessionals include: certified nurse aides, nursing assistants, orderlies, personal care workers, personal care attendants, personal aides, home health and home care aides, and others. Paraprofessional staff provide assistance with ADLs such as bathing, dressing and eating as well as IADLS such as meal preparation, house cleaning, and medication management. These paraprofessionals work in a variety of long-term care settings including nursing homes, assisted living, residential care settings, adult day care, group homes and private homes. Experts have noted that paraprofessional long-term care workers form the centerpiece of the formal long-term care system.[27]

[26] This number does not include licensed practical and licensed vocational nurses who worked in hospital settings with post-acute and long-term care beds.

[27] Stone, Robyn; Weiner, Josh, "Who Will Care For Us? Addressing the Long-Term Care Workforce Crisis, prepared under contract for the Robert Wood Johnson Foundation and Office of the Assistant Secretary for Planning and Evaluation, HHS, October, 2001.

1. Nursing Aides, Orderlies and Attendants[28]

Nursing aides, orderlies and attendants represent the majority, approximately 62 percent (645,000 of 1,038,000), of the direct care workforce in nursing homes andpersonal care facilities[29] and 11 percent (87,000 of 816,000), of direct care workers in residential and home health care settings. As the main provider of "hands on care" in these institutional settings, they help people with basic activities of daily living (such as bathing, dressing, toileting, eating and transferring), instrumental activities of daily living (such as room cleaning, and medication management), as well as keep records of services delivered and changes in the client's conditions. Nurse aides who work in Medicare and Medicaid certified nursing homes must complete a 75 hour training course in order to become a certified nurse assistant (CNA).

BLS estimates that nursing aides, orderlies, and attendants held approximately 645,000 jobs in 2000 in nursing homes and personal care facilities.[30] The BLS projects over the period from 2000-2010 that 153,000 new jobs for nurse aides, orderlies and attendants will be created in nursing home and personal care facility settings, a 24 percent increase. In addition to occupational employment growth, 95,000 job openings will result from the need to replace nurse aides, orderlies and attendants who leave the occupation permanently to enter other jobs, retire, or leave the labor force for other reasons.

Several supply-side factors may be combining to constrain the supply of nursing aides, orderlies and attendants in long-term care settings including:

- Competitive and adequate wages is one of the most often cited reasons for high turnover among nursing aides, orderlies and attendants. The median hourly wage for nursing aides, orderlies and attendants was $8.89 per hour in 2000.[31, 32]

- One in three nursing aides in nursing homes earned less than $10,000 per year, and 36 percent reported family incomes below $20,000; 18 percent of nursing

[28] As defined by the BLS, nursing aides, orderlies and attendants provide basic patient care under direction of nursing staff. They perform duties such as feed, bathe, dress, groom or move patients, or change linens.

[29] Bureau of Labor Statistics, National Employment Matrix, 2000-2010.

[30] Bureau of Labor Statistics, National Employment Matrix, 2000-2010.

[31] Bureau of Labor Statistics, Occupational Employment and Wages, 2000.

[32] For comparison purposes, the median hourly wage for floral designers was $8.83 in 2000; crossing guards $8.37; fast food cooks $6.53; motel desk clerks $7.87. (Ibid, 2000.)

aides working in nursing homes and 19 percent working in home health care have incomes below the poverty level.[33]

- Stigma associated with being in a CNA job in long-term care settings.
- Lack of respect and feeling undervalued by supervisors.[34]
- Strenuous physical demands of working in nursing homes, as compared to other health and non-health related industries (13.9 employees per 100 employees in nursing and personal care facilities had a workplace injury in 2000 compared to 5.3 employees per 100 in eating and drinking places, or 9.1 per 100 in hospital settings).[35]
- Staffing levels of CNAs are inadequate to accommodate workloads in nursing homes (HHS nursing home staffing report).
- The competing demands of providing individualized services to residents and meeting institutional requirements for efficiency and volume of work are causing nurse aides to become increasingly frustrated with their jobs.[36, 37]
- Inadequate training provided for the job (2000 IOM Study).
- Limited job mobility (2000 IOM Study).
- Lack of child care (state survey).
- High turnover rates (the annualized turnover rates of nurse aides have been estimated to be a high as 76 percent).[38]

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[33] GAO analysis of CPS data included in "Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is A Growing Concern," May 17, 2001.

[34] Institute of Medicine, Committee on Nursing Home Regulation. 1986. Improving the Quality of Care in Nursing Homes. Washington, D.C.: National Academy Press.

[35] Occupational Injury and Illness Survey of Occupational Injuries and Illnesses, Bureau of Labor Statistics, 2000.

[36] Foner, Nancy, "The Caregiving Dilemma: Work in An American Nursing Home", 1994.

[37] Salsberg, Edward, " Assuring an Adequate Supply of Health Workers To Provide High Quality Care to America's Seniors", January 14, 2002.

[38] American Health Care Association, Preliminary Results of the 2001 AHCA Nursing Position Vacancy and Turnover Survey, Washington, October, 2001.

- Aides in long-term care settings are less likely than other workers to have employer-sponsored health insurance and much less likely to be covered by a pension (from GAO report--get CPS data to verify).

2. Home Health Aides and Personal and Home Care Aides

While we have relatively good understanding of the number of registered nurses, licensed practical and vocational nurses, and nursing aides, orderlies and attendants in long-term care settings, we have less comprehensive data on home health aides and personal care aides. Home health aides, by BLS definition, "provide routine, personal healthcare, such as bathing, dressing, or grooming, to elderly, convalescent, or disabled persons in the home of patients or in a residential care facility", personal care and home health aides, by BLS definition, "assist elderly or disabled adults with daily activities at the person's home or in a daytime non-residential facility." For descriptive purposes, these workers have virtually identical skills and occupational definitions, so we have grouped them together.

Home health, personal care and home care aides represent the majority, approximately 67 percent (548,000 of 816,000), of the long-term care direct care workers in the community (residential care and home health care settings). This estimate undercounts the number of home health care, personal care and home care aides because it excludes hospital-based workers, independent providers, and public agency workers.[39] As the main provider of "hands on care" in these residential and home health care settings, they help people with basic activities of daily living (such as bathing, dressing, toileting, eating and transferring), as well as instrumental activities of daily living (such as meal preparation, house cleaning, and medication management). All aides delivering services outside of facilities keep records of services and changes in clients' conditions. Requirements regarding training and certification for home health care and personal and home health aides vary by state.

BLS estimates that home health, personal care, and home care aides held approximately 548,000 jobs in 2000 in community settings, and 47,000 jobs in 2000 in nursing and personal care facilities. The BLS projects over the period from 2000-2010 that 394,635 new jobs for home health, personal care, and home care aides will be created in all long-term care settings, a 66 percent increase. In addition, to occupational employment growth, 82,000 job openings will result from the need to replace home health, personal care and home care aides who leave the occupation permanently to enter other jobs, retire, or leave the labor force for other reasons.

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[39] As many as 1 million additional home health workers work privately for consumers, or work for public authorities (Eckels, 1997). In addition, California has a very large public authority that employs about 300K independent home care workers in its In-home Supportive Services Program.

Several supply-side factors may be combining to constrain the current and future supply of home health care workers including:

- Changes in reimbursement (prospective payment) in Medicare home health have reduced the number of client visits and hours per visit (GAO report) reducing the number of home health aides in home care settings.

- The level of wages paid may be too low to attract new workers--unlike RNs, LPNs and some CNAs, there are no standards within the home health care industry for worker wages and benefits; in 2000 the median hourly wages of personal and home care aides was $7.50.[40, 41]

- Most home care workers in community settings are independent providers and have few benefits (health, pension or disability coverage) (Himmelstein et al., 1996).

- Employer sponsored benefits may not exist for many home health and personal care aides.[42]

- Inadequate supervision and support--nursing staff may be responsible for more than 100 aides but have not had formal training in supervision (Surpin & Grumm, 1990).

- Home health workers generally have poor opportunities for advancement and limited opportunities for upgrading their skills (Surpin and Grumm, 1990).

- Training provided to aides is low (usually 75 hours for home health aides)--not preparing them for the stresses of the job.

- The stigma of working as a home health care worker--treated like a “girl” or “maid” (Wilner, Wyatt, 1998); lack of recognition and support from the client and the agency; home care workers perceived as an extension of domestic work (Surpin, Haslanger & Dawson, 1994).

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[40] Bureau of Labor Statistics, Occupational Employment and Wages, 2000.

[41] For comparison purposes the median-hourly wages for fast food cooks was $6.53 in 2000; dishwashers $6.69; maids and housekeeping cleaners $7.41; service station attendants $7.35; and child care workers $7.43.

[42] One third of home health aides and one fourth of nursing home aides do not have any form of health insurance compared to 16 percent of all workers. U.S General Accounting Office. Health Workforce Ensuring Adequate Supply and Distribution Remains Challenging, August, 2001.

- Home care is classified as an unskilled labor (waits of 10-15 years for work permits)--more difficult for home health care workers to immigrate from other countries, limiting supply.

- Larger number of under-represented minorities are found in lower paying health occupations such as home health aides.[43]

- State nurse practice act regulations may prohibit the provision of any skilled nursing care under the guise of personal care assistance--some states allow nurse delegation of tasks (Kane 1995) (Need to Update this--e.g., Susan Reinhardt report).

[43] Salsberg, Edward, "Assuring an Adequate Supply of Health Workers To Provide High Quality Care to America's Seniors", January 14, 2002.

III. DOL AND HHS AGENCY EFFORTS ALREADY UNDERWAY

There are a number of provider-based and state-wide activities to increase the recruitment and retention of direct care workers in long-term care settings. Much progress is already being made in many jurisdictions to address long-term care workforce issues such as wages and benefits, training and career development. States have been particularly active in establishing legislative priorities vis-a-vis nurse staffing and nursing education. States have also recognized the need to intensify and systematize data collection efforts. These initiatives and activities are documented in "Who Will Care For Us", a white paper prepared for HHS by the Urban Institute and Institute for the Future of Aging Services (Appendix A), and in "State Long-Term Care Workforce Initiatives" prepared for DOL and HHS by the Urban Institute (Appendix B).

In this section, we focus on federally initiated activities already underway that are aimed at developing a committed and quality direct care worker pool in a variety of long-term care settings. These activities are grouped by agency/office, and include: training and technical assistance for workers, employers, and states; direct assistance to providers, states, students and schools; and, collaborative efforts.

A. Collaborative Efforts Between HHS and DOL

Memorandum of Understanding: DOL, HHS and Education drafted a Memorandum of Understanding, which features an agreement of the agencies on joint action strategies that address regional and local nursing and allied health occupational shortages. The joint effort will better link existing efforts among the agencies. The joint initiative will promote nursing as a career, seek to expand enrollment in nursing programs at all levels and create a nursing career ladder pilot program linking Job Corps to nurses aid apprenticeships, community colleges, vocational and professional nursing education programs.

HHS and DOL "Toolkit" Project: DOL and HHS have come together in a new initiative to address workforce shortages in long-term care settings. The initiative is a two-year research project to develop a "toolkit" to enable state agencies, long-term care providers, and worker groups assess the impact of policy and practice changes designed to reduce vacancy and turnover rates among direct care workers and to improve workforce quality. This joint initiative will help states collect data that will allow for comparisons across recruitment and retention efforts.

National Panel on Nursing: DOL and HHS are tasked with convening a national panel to examine education and training requirements for all nursing occupations. The two agencies will work with the American Nurses Association and other nursing affiliated groups in this effort. DOL and HHS have begun conversations on how to best assemble the national panel on nursing.

B. Department of Labor

1. Employment and Training Administration (ETA)

Electronic Information Systems: DOL has established a specialized on-line job bank, CareCareers.net, dedicated to linking job seekers to new careers in long-term care nursing. The project, announced in April 2002, utilizes existing resources available through ETA's electronic tool kit and is a collaborative venture with the American Health Care Association and the American Association of Homes and Services for the Aging. This new job bank is part of the computerized information systems that are a key part of the One-Stop system. The overall system includes America's Job Bank (www.ajb.org), America's Career InfoNet (www.acinet.org), America's and America's Service Locator (http://www.servicelocator.org). In addition, ETA also funds and manages O*NET (http://www.doleta.gov/programs/onet), a database of occupations and their requirements that can be used by job seekers, employers, educators and training professionals. O*NET also includes three career exploration tools.

Targeted High-Growth Job Training Initiative: The President's FY 02 supplemental budget proposal provides up to $50 million to support a Targeted High-Growth Job Training Initiative that leverages private sector dollars in order to target job training for skills-in-demand. As part of this initiative, DOL has embarked on several national-level partnership activities involving employers. One such public-private partnership is between the Department of Labor and HCA, Inc., the nation's largest manager/owner of hospitals and other health care facilities, some of which will involve long-term care settings. DOL and HCA are each contributing $5 million to offer scholarships and certification to workers dislocated as a result of September 11th who choose to pursue careers as RNs, LPNs, CNAs, and radiological or surgical technicians. DOL is also working to develop a project to recruit dislocated workers in the hospitality industry for positions in health-related fields, utilizing the resources available through ETA's electronic tool kit and the One-Stop Career Center infrastructure.

Local Health Care "Sectoral" Initiatives: DOL is funding pro-active local "sectoral" efforts that merge economic development with workforce development concerns, thereby permitting more strategic approaches to employment issues. While these projects are not targeted specifically on long-term care needs, they could provide a model for how to address them at the local level. The sectorial approaches cover a

wide range of human resource interventions that go well beyond training to encompass career ladder development, compensation, working conditions, organizational structures, recruitment channels, and retention strategies. Funds for these sectoral projects are provided through demonstration grants to local Workforce Investment Boards (WIBs) created under the Workforce Investment Act.[44] The grants are targeted to specific industries, of which health care is one of the major sectors, with 20 of the 39 sectoral grants focusing on this area. Health care sectoral projects have involved a broad range of activities, including building local or regional consortiums of hospitals and training providers, development of new programs to upgrade the skills of current health care workers, and changes in employer policy practices to increase wages and benefits for direct care workers. DOL is developing a Health Care Sector Initiative Primer to provide local workforce areas under WIA with step-by-step, "how-to" guidance on replicating similar sectoral projects.

Pilot and Demonstration Programs: DOL manages other pilot and demonstration projects which have supported training in health-related professions. In particular, there have been a number of dislocated worker projects oriented toward retraining laid-off workers for health occupations or for upgrading the skills of health care workers at risk of job loss. An example of a recent project is one aimed cross-training and upgrading home care workers in New York City. Because of state restraints on Medicaid-financed personal care services, worker skills had to be upgraded in order for them to qualify to provide Medicare services and enhance their employability.

National Emergency Grants: DOL provides additional funding for worker re-employment and retraining programs in local areas or states that have experienced large worker dislocations. Several of these National Emergency Grants (NEGs) have been used, at least in part, for retraining dislocated workers in health care professions.

Health Care Apprenticeship Programs: DOL also administers a national system for registered apprenticeship training programs that consist of structured on-the-job training and related theoretical instruction tailored to industry requirements. The programs are operated primarily by individual employers, employer associations, or partnerships between businesses and labor unions, with involvement of education providers, such as community colleges. DOL has certified 36 nursing-related

[44] One of the pivotal areas that could be mobilized to address potential shortages in long term care at the local and state level are the One-Stop Career Center Systems created under Title I of the Workforce Investment Act (WIA). These systems provide a range of services such as career information, job vacancy information, job search assistance, placement assistance, counseling, and training through 605 local workforce areas managing over 1,300 local One-Stop Career Centers. Local and state One-Stop Systems are overseen by Workforce Investment Boards, charged with identifying and addressing strategic issues in workforce development. One-Stop Career Center Systems also require participation by numerous other federal programs and their local and state agencies.

apprenticeship programs in 14 states, in such fields as nursing assistants and Licensed Practical Nursing, among others.

Apprenticeship Pilots: ETA is currently conducting a pilot project (the Apprenticeship Health Care Outreach Initiative) to expand the number of employers and apprenticeship programs in the health care field, targeting paraprofessional occupations, such as CNAs, LPNs, radiological technicians, opticians, and home health aids, which require a two-year degree or less. ETA field staff are working to establish apprenticeship programs with hospitals, nursing homes, and other health care facilities that employ these workers. An example of an emerging project is one in Washington state, where ETA is working with employers, county government and community colleges to create new apprenticeship programs in high demand health care occupations that the colleges do not have sufficient slots to train. Another example is in Missouri where an apprenticeship program for Direct Support Professionals has been developed.

Youth Programs: DOL administers a number of youth programs all of which could potentially train young people to fill health-related occupations in the long-term care field. The programs include "formula-funded" services provided through states and local communities; "Youth Opportunity Grants" competitively awarded to serve youth in high-poverty urban, rural, and Native American communities; and residential education and training through the Job Corps. Formula-funded youth services are administered by local workforce investment boards to provide a variety of in-school and out-of-school services targeted to low-income youth. Job Corps, the nation's largest residential education and job training program for at-risk youth, has over $20 million invested in health related training, and is producing over 4,700 health-trained workers on an annual basis. Nearly all of the 120 Job Corps centers offer at least one health training program in 15 specialty areas including Certified Nursing Assistant (CNA), Medical Assistant, Licensed Practical Nurse, and Physical Therapy Assistant.

Senior Community Service Employment Program: DOL administers over $400 million in grants to a not-for-profit organizations and states to provide part-time community service employment, training, and job placement to low-income workers 55 years of age or older. The program annually employs around 100,000 people in a total of 61,000 job slots. Many of these jobs are associated with service to the aging population and assistance that enables individuals to remain in their home. For example, some workers assist in Meals-on-Wheels programs or in filling administrative jobs in organizations that provide services to the elderly.

H-1B Technical Skill Training Grants: Under the American Competitiveness in the Twenty-First Century Act of 2000 and similar prior legislation, DOL provides Technical Skill Training Grants to train domestic workers in specialty occupations being filled by temporary workers admitted under H-1B visas. The grants are awarded to

Workforce Investment Boards and to business partnerships using a portion of the fees collected from employers applying for H-1B visas. Out of the $196 million for training grants provided so far, approximately $26 million has been channeled to for health-related projects that provide training to entry-level workers and upgrade the skills of incumbent workers in the health field, with some providing workers for long-term care settings. In the 2003 budget, the Administration proposed eliminating funding for these training grants.

Welfare-to-Work: A component and partner in local One-Stop systems are Welfare-to-Work (WtW) grantees, who receive formula funds and competitive grants to provide placement, transitional employment, and other support services targeted to the hardest-to-employ custodial and non-parents under Temporary Assistance for Needy Families (TANF) and other low-income families. A number of local competitive and formula-funded projects placed recipients in health-care occupations, though not necessarily for long-term care settings. Though the Administration is not seeking funding or re-authorization of the WtW program, various projects offer models for states and localities to use in helping former TANF recipients or other low-income individuals find work in or train for long-term care occupations.

An example of projects include those such as the Pathways to Advancement Project, a partnership between DOL and HHS with non-profit organizations. The project involves using funds from TANF, WtW, and WIA to partner with employers and educational institutions to test a model program to help former TANF recipients become entry-level workers, retain their jobs, and eventually move into second tier jobs with better pay, benefits, and training opportunities. One site, Seattle, has exclusively targeted the health care industry, including long-term health care.

Foreign Labor Certification Programs: The Department of Labor administers several programs to permit foreigners to legally enter the U.S. to work. One such program is the H-1C Temporary Program for RNs in Shortage Areas. The Nursing Relief for Disadvantaged Areas Act (NRDAA) of 1999 allows qualifying hospitals in designated Health Professional Shortage Areas to temporarily employ foreign RNs for up to three years underH01C visa. Only 500 visas per year have been allocated for the four years of the program (2000-2004). Nurses working under H-1C visas can only work for the employer requesting them. The program was enacted to provide nurses in the inner city and rural areas, which experienced severe shortages in health care professionals. Should the need arise, there are other labor certification programs that could be used to increase the number of foreign workers in different occupational areas related to long-term care.[45]

[45] These programs include the Permanent Labor Certification Program and the H-1B Temporary Program for Nonimmigrant Professionals. The Permanent Labor Certification Program allows foreign workers to emigrate to the U.S. to work and become permanent resident aliens. Immigrants must have an offer of permanent employment from

2. Occupational Safety and Health Administration (OSHA)

Safety and Health Initiatives for Front-Line Caregivers: Working closely with industry, DOL's OSHA has initiated a National Emphasis Program for Nursing and Personal Care Facilities, Skilled Nursing Care Facilities, and Intermediate Care Facilities. This program's focus is on reducing specific hazards that account for the majority of nursing home staff injuries and illnesses such as back injuries from patient handling, blood-borne pathogens, tuberculosis, and slips, trips, and falls. The first industry-specific guidelines to reduce ergonomic-related injuries and illnesses are now being developed for nursing homes with assistance from representatives of the industry. The initiative will involve outreach to operators of nursing homes and other care facilities with information on how to identify and prevent safety and health hazards and a focus on inspections and appropriate follow-up as needed.

3. Employment Standards Administration (ESA)

Wage and Hour Compliance Assistance in the Long-Term Care Industry: DOL's Employment Standards Administration's Wage and Hour Division is focusing resources to improve compliance with labor standards among industries that employ a high concentration of low-wage workers and for which enforcement data and history show high rates of serious violations. Since 1997, the long-term health care industry (including nursing homes, adult family care, assisted living, group homes and residential living facilities) has been the subject of this national initiative. Currently, the effort focuses on compliance education, employer outreach, and strategic partnerships with industry stakeholders.

4. Veterans Employment and Training Service (VETS)

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an employer and they and their employer must jointly seek and obtain a certification from the Department of Labor. The application and approval process can be time-consuming and there are considerable backlogs (up to several years). Time-reducing exceptions exist within the labor certification process, such as for workers in designated shortage occupations who must apply in conjunction with an employer. This "Schedule A" exception for shortages is currently applicable to such occupations as registered nurses and physical therapists and could be expanded to long-term care occupations including LPNs, CNAs, and home health aides, should they be designated as having shortages.

Through the H-1B Temporary program, employers can hire foreign workers in professional occupations for a temporary period. Employers must file applications with the Department stating that they will pay the prevailing wage, have notified union representatives, and that there is no strike or lockout at the place of employment. This program may be used for nursing, but only for those positions that require a bachelor's degree. INS restricts this program to more specialized or supervisory nurses and makes the determination as to who can and cannot be hired. Foreign workers who work under H-1B can only work for the employer who requested them. No H-1B nurses were requested in FY 2000.

Transition Assistance Program (TAP): TAP was established to meet the employment needs of separating service members during their period of transition into civilian life by offering job-search assistance and related services. The TAP program was established under a partnership between the Departments of Defense, Veterans Affairs, Transportation and DOL's VETS, give employment and training information to armed forces members within 180 days of separation or retirement. TAP consists of comprehensive three-day workshops that cover topics such as job searches, career decision-making, current occupational and labor market conditions, evaluations of participant's employability, and information on the most current veterans' benefits. VETS is currently in the planning stages of two pilots for a medical employment project. This project will provide transition military personnel with opportunities to advance their medical skills learned while in the service or to transition their skills into the medical field. One site involves partnerships with Johns Hopkins University, the state workforce agency, the Governor's Workforce investment board, and the Department of Defense. The second pilot site will be located in San Diego and features Kaiser-Permanente as the primary employer and will serve both veterans and spouses of military members. VETS recently provided a memo to TAP to inform them of the shortage of qualified health care workers and to encourage the promotion of the health care industry as a viable career to those separating and retiring service personnel.

5. Bureau of Labor Statistics (BLS)

The Department of Labor, serves as the primary source for national workforce data. The BLS administers two surveys that are used to measure and describe the labor force and project future occupational employment. The Current Population Survey (CPS), a monthly survey of approximately 60,000 households conducted by the Census Bureau for BLS collects data on employment, unemployment, demographic characteristics, and wages. Staffing pattern data from the Occupational Employment Statistics (OES) survey are a major input into the BLS occupational employment projections that are published every two years, and forecast 10-14 years into the future. The Employment and Training Administration, which collects labor certification data, administers a number of foreign labor certification programs to assure that admitting foreigners to work in the United States will not adversely affect the job opportunities, wages and working conditions of American workers.

C. Department of Health and Human Services

1. Centers for Medicare and Medicaid Services (CMS)

Real Choice System Change Grants: CMS, under the Real Choice System Change Activities, have made grant funds available to States who are designing systems of care to support people with disabilities in community-based settings. Over 15 states have initiated state-based or provider-based initiatives designed to improve and develop the long-term care workforce capacity in community-settings. (NEED SPECIFIC INFORMATION FROM FORMATIVE EVALUATION OF THE STATES IN THIS AREA).

Medicaid Infrastructure Grants: CMS, under the Ticket to Work and Work Incentives Improvement Act of 1999, established a grant program to support State efforts to enhance employment options for people with disabilities. The goal of the Medicaid Infrastructure Grants program is to support people with disabilities in securing and sustaining competitive employment in an integrated setting. Several grants have been awarded to states to build the adequacy and availability of personal assistant services in community based settings, in order to enable more individuals with disabilities to become employed.

Examining the Adequacy and Availability of Personal Assistant Services: CMS has developed a project entitled, "Understanding the Adequacy and Availability of Community-Based Personal Assistance Services." The purpose of this technical assistance project is to evaluate the size and scope of the shortage of personal assistance services and to explore policies and practices that influence the recruitment and retention of qualified personal assistance services workers. The work will include: (1) the development of practical, useful, community-based products that can be used to address workforce shortage issues; (2) an electronic database of resources, contacts and tools to be used by federal, state and local organizations in designing and implementing policies and programs to increase the availability of personal assistance services workers (this database will include querying capabilities); (3) development of a foundation for future research in community-based personal assistance services and supports; (4) an identification of areas needed for additional research or for policy or programmatic changes; and (5) immediate assistance to new projects funded under the Systems Change grants related to workforce development in community-based care settings.

2. Health Research and Services Administration (HRSA)

Advanced Education Nursing Program: HHS's Advanced Education Nursing Program supports projects educating nurses for faculty positions in nursing schools,

public health nurses, nurse administrators and advanced practice nurses which include nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives. Funds from this program support advanced education projects enrolling approximately 4,550 students and provide traineeship support for 5,800 graduate level students. There are 61 schools that provide traineeships for graduate students specializing in geriatric nursing. In 2002 four schools of nursing are supported for continuation grants with a geriatric focus. These projects have a total 2002 budget of $941,352. Six new geriatric grants are also funded in 2002. The new grants are projected to benefit 489 students over three project years with total 2002 funding of $1,487,951. These six new and four continuing geriatric grants are funded in 2002 for a total of $2,429,303. The total Advanced Education Nursing Program budget for 2002 was $60 million and $60 million is also projected for 2003.

Nursing Workforce Diversity Program: HHS's Nursing Workforce Diversity Program provides support to projects targeting 1,800 minority and disadvantaged students in elementary and secondary schools, pre-nursing programs and nursing schools. This program provides enrichment and support services necessary to assure successful completion of those students enrolled in nursing programs ($6.2 million in 2002 and $6.2 million in 2003).

Basic Nurse Education and Practice Program: HHS's Basic Nurse Education and Practice Program supports academic and continuing education projects designed to recruit and retain a strong nursing workforce. Funds are used to support basic entry-level career ladder programs for licensed practical nurses, innovative academic distance learning projects for rural RNs, and projects to expand enrollments in baccalaureate programs. Support is provided for developing cultural competencies among nurses and to support retention strategies through continuing education projects to enhance the skills of the existing nursing workforce for practice in existing and emerging health care systems. In addition, support for faculty-run nurse managed centers provides educational settings for nursing students and clinical practice sites for faculty providing care to underserved populations. The program funds schools of nursing for the training of nurses with a focus on improving curricula and clinical practice to provide care to underserved populations. The Nursing Faculty Development in Geriatrics funded by the Basic Nurse education and Practice Program funded three grants in April 2002 for total year one funding of $1,487,951. (See Appendix E for full list of three grants.) The grantees project that 191 faculty members will be prepared in geriatric nursing in three project years. The Geriatric Nursing Knowledge and Experiences in Long Term Care for Baccalaureate Nursing Students initiative is to assist eligible entities to strengthen the geriatric nursing didactic content and clinical components of their baccalaureate nursing program. The intent was to provide funds to encourage integration of geriatric content and experiences throughout the nursing curriculum which would continue in place beyond the one year funding period. The program supported ten awards of approximately $25,000 each, and a reported total of

660 students participated in geriatric courses and clinical experiences during these one year projects. Total program support was $16.3 million in 2002 and budget projected at $16.3 million in 2003.

Nursing Education Loan Programs: HHS's Nursing Education Loan Repayment Program provides loan repayment for nurses who agree to serve for not less than two years in designated health facilities (FWHCs) $10.2 million in 2002, and $15 million in 2003.

HHS's Revolving Nurse Loan Fund Program provides funds to students at academic institutions to support 10,000 nursing students $22 million in 2001--no new funds.

HHS's National Health Service Corps Loan Repayment and Scholarship program provides scholarships to nurse practitioners, nurse midwives and physician assistants. In 2001, there were approximately 300 nurse practitioners and 65 nurse midwives in the field. (Any information of long-term care setting.)

HHS's Faculty Loan Repayment provides loan repayment to faculty from disadvantaged backgrounds. $.5 million in 2002.

HHS's National Institute of Nursing Research supports clinical and basic research related to nursing's contribution to patient care, some funds are used for research training $117 million in 2002, $105 million in 2002.

Geriatric Education Centers: HRSA's Geriatric Education Centers (GECs) strengthen multidisciplinary training of health professionals to diagnose, treat and prevent disease and other health problems of the elderly. GECs improve the training of health professionals in geriatrics and provide students with clinical training in geriatrics in nursing homes, chronic and acute care hospitals, ambulatory care centers and senior centers. GECs provide services to and foster collaborative relationships among health professions educators (organizations and institutions that sponsor formal and informal educational programs and activities for faculty, students and practitioners) within defined geographic areas (states, counties, metropolitan areas or portions thereof). GEC grants are made to accredited health professions schools. States match HRSA funding by on average, $3 (state) :$1 (federal). Since 1983, GECs have trained nearly 400,000 health professionals in 25 disciplines. In FY 2000, GECs trained approximately 20,000 health professionals, including 2,400 nurses. HRSA anticipates awarding $12.7 million to GECs in FY 2002. (See Appendix D for list of Advanced Education Nursing Program Grants with a Geriatric Focus.)

Regional Centers for Workforce Studies: HRSA has funded four Regional Centers for Health Workforce Studies to examine geographic imbalances across five

health professional disciplines: medicine, nursing, dentistry, allied health and public health. The Centers work with State agencies and conduct research, including state and regional studies, and develop analytic tools that help states resolve pressing issues in health professions training.

National Sample Survey of Nurses: HRSA's National Sample Survey of Registered Nurses (NSSRN) is the nation's most extensive and comprehensive source of statistics about licensed registered nurses in the United States. The sample is drawn from the universe of all licensed RNs, whether or not they are part of the labor market. It collects information on the number and characteristics of licensed RNs; their education background and specialty areas; their employment status including type of employment setting, position level, and salaries, their geographic distribution; and their personal characteristics including gender, racial/ethnic background, age, and family status. Information is collected on RNs employed in long-term care hospitals and nursing homes. In addition, information is collected on RNs employed in home health care (which includes both short and long-term care).

Nursing Supply Forecasting Model: HRSA's Nursing Supply Forecasting Model is a statistically based model that projects the future supply, and FTE of registered nurses for each of the 50 States and the District of Columbia. The Nursing Supply Model captures age-specific dynamics of the flow of nurses in and out of licensure and the workforce; their progression from one educational level to another; and their state-to-state mobility.

Nursing Demand Model: HRSA's Nursing Demand Model is a statistically-based model used to forecast future requirements for registered nurses, licensed practical nurses, and nursing aides. The nursing demand projections are based on health care utilization, changing demographics, and the health care delivery system. Projections can be made to the year 2020. The model incorporates the capability of forecasting health service requirements for thirteen health care sectors, including several long-term care settings: long-term care hospitals, nursing homes, and home health care. Projections are available can be made for including registered nurses, licensed practical nurses, and nursing aides. The projections are made at the national and state level.

HRSA utilized the Nursing Supply and Demand models to project the supply, demand, and shortages of RNs over the period 2000-2020. This report is in the clearance process now.

Study on Nursing Aides and Home Health Care Workers: HRSA is completing a study, Nursing Aides and Home Health Care Aides--Supply, Demand, Data Sources and Data Issues. This study provides an in-depth investigation of nursing aides and home health care aides, including their role in long-term care settings, the dynamics of

the market, state and national data sources, and identifies problems and makes recommendations regarding data collection.

3. Office of the Assistant Secretary for Planning and Evaluation (ASPE)

Technical Expert Meetings on Paraprofessional Long-term Care Workforce: ASPE held a series of three technical expert panels on the topic of frontline workers in long-term care settings. The purpose of this project was to heighten the awareness among federal, state, and local policymakers, long-term care providers, consumers, and foundations about the issues related to the frontline long-term care paraprofessional workforce, including people who work for nursing homes, home care agencies and non-medical residential facilities and people who work as independent providers. This project sought to: identify successful training, recruitment and retention models for frontline workers, identify training needs, analyze policy options, identify data gaps, and develop a research and demonstration strategy that the government and foundations can undertake to improve policymaking.

National Initiative for Direct Care Workers: ASPE, in collaboration with the Centers for Medicare and Medicaid Services has a project entitled, "Development of a National Initiative for Direct Care Workers." The purposes of the project are to: (1) increase public recognition of the critical role played by direct care workers, (2) promote innovation at the state, community and provider level to improve recruitment and retention of workers, (3) create a national clearinghouse database on the long-term care workforce with search capacity, (4) increase understanding of the causes of worker shortages and the likelihood they will persist in the future so that new policies, programs and practices can be implemented to resolve them, and (5) collaborate with potential funders to plan and implement a systematic program of applied research, demonstration and evaluation to improve workforce recruitment and retention and the delivery of high quality long-term care services.

4. Agency for Health Care Research and Quality (AHRQ)

Workshops for Providers and Policymakers: AHRQ held a workshop to provide state and local health policy makers with an overview of the major issues underlying the shortage of paraprofessional workers in long-term care settings and potential strategies to address the problem. The workshop included sessions on the supply and demand of paraprofessional workers, working conditions and job design, management of the work environment, and wages and benefits. The workshop also highlighted industry and state initiatives that address these issues including workforce recruitment strategies, new models for organizing long-term care services, and the role of "informal" caregivers.

IV. FACTORS ASSOCIATED WITH SHORTAGE AND RECOMMENDATIONS

Assuring there are is adequate number of competent and compassionate caregivers for the elderly and disabled in the 21st century will require retaining current workers and attracting new ones. To do so will require addressing key issues, as summarized below:

Compensation, Benefits and Advancement: Wages for RNs and CNAs in long term care settings are appreciably lower than they are in hospital settings, and for CNAs, home health workers and personal care aides wages are at low levels when compared to other low wage, low skilled occupations (though rising in some parts of the country). In addition, many workers lack health insurance, pension coverage, and childcare benefits, particularly those in informal care settings and in lower skill positions. Finally, many occupations, such as home health workers and certified nurse assistants, do not have career ladders or opportunities for advancement.

Working Conditions: Hours, Paperwork, Respect, and Safety: Workers in many long-term care settings complain about long hours, burdensome paperwork, lack of respect, and potential dangers to their own health and safety. Improving these working conditions has the potential to improve the retention of workers in long-term care settings and to make these occupations more attractive to new workers.

Finding New Sources of Workers: Avoiding shortages in different occupations will depend not only on retaining current workers but also on increasing the overall supply. Identifying and tapping new workers among older workers, former TANF recipients, and veterans, will help to assure there will be enough nurses and paraprofessionals in the immediate future and over the longer term. Exploring the feasibility of expanding existing immigration programs for direct care workers in long-term care settings will be important. Assuring there are adequate numbers of faculty to train these potential long-term care workers must also be addressed.

Initial and Continuing Education and Training of Workers: Effective education and training of long-term care workers is essential if they are to have appropriate and high levels of skills. In some occupations, such as personal assistants for the working disabled, there are few programs and relatively little curriculum. To address these issues will require sustained effort on the part of many.

Below are comprehensive recommendations guided by a recognition that the key players in crafting and implementing solutions will be employers and industry representatives, educational institutions, faith and community-based organizations,

workers themselves, as well as many public agencies, elected officials and legislators at the federal, state, and local level. The recommendations include both those that are cross-cutting and those that relate to specific issues of concern.

RECOMMENDATIONS

National Dialogue With Employers: Engage employers and employees, medical professionals and state and local government officials, in a dialogue on issues relating to pay, benefits, career ladders, and working conditions in long-term care.

Outreach to Faith and Community-Based Organizations: Explore with faith and community-based organizations their potential role, particularly how they might help increase the number of volunteers for a variety of long-term care needs, such as respite care for family members, assistance to the working disabled, "back-up" services, and home-based support.

Support for State and Local Initiatives: Encourage and support state and local efforts, involving both the private and public sectors, including exploring:

- Expanding use of the local "sectoral" approach (building on DOL initiatives as a model) to support efforts to organize consortiums involving employers, training providers and public agencies to attract new workers, enhance pay and working conditions, and provide both initial, upgrade, and in-service training for long-term care workers.

- Assuring that One-Stop Career Center Systems nationally promote job seeker awareness of the full range of long-term care occupations (including CNA, RNs, LPNs and home health aides) and relay accurate information on training requirements stipulated under Medicare and Medicaid for such occupations.

- Encouraging local public agencies and Medicaid and Security Agencies to provide counseling for workers to help them get the public benefits they are eligible for--Medicaid, EITC, child care, and other benefits. The role of One-Stop Career Center systems in providing this information as should be explored.

- Explore ways to actively encourage states to increase recruitment and training for long-term care workers.

Regulatory Changes: Explore areas for potential federal and state regulatory changes, which could include determining if there are unnecessary or duplicative regulations that could be eliminated with compromising quality oversight and monitoring mechanisms.

Enhanced Use of Technology: Explore use of new technology in recruitment, education, record-keeping and patient care. This could range from publicizing the on-line job bank (CareCareers.net), building a web-based information source on education and training for nurses and paraprofessional occupations, establishing an on-line registry for locating personal assistants for the working disabled, to exploring better use of technology for record-keeping, patient care and patient monitoring.

Support Research Efforts to Inform Policy Makers: Support additional research and data collection to inform policy makers at all levels of government. Explore specific areas for such data collection and research activities such as:

- Monitoring and analyzing wage and benefits trends among long-term care workers in different work settings.

- Evaluation of approaches such as state-enacted "wage pass throughs" and their impact on recruitment, retention, and quality in different occupations, and demonstration research such as the "CMS Health Care Voucher Demonstration For Frontline Long-Term Care Workers."

- Support research and data collection activities monitoring the wages of direct care workers, and examine wage differentials among workers.

- Support additional research to understand the types of direct care workers likely to have benefits and the settings in which they work.

- Building stronger data, research and evaluation capabilities at the federal and states level in order to better inform policy-makers, including possible expansion of several specific workforce analyses and surveys of direct care workers in long-term care settings at HHS.

Enhanced Training and Education: Support multiple initiatives including:

- Developing a national initiative to expand the cadre of instructors for nursing and paraprofessional occupations through a coordinated effort, involving state and local government as well as professional nursing organizations and employee representative groups. Consider possible federal "seed" money and scholarships with federal and state funding.

- Supporting public sector approaches designed to leverage private sector funds, similar to DOL's Targeted High Growth Training Initiative.

- Encouraging state educational systems and state funders to expand the number of slots for training nurses and paraprofessionals in four-year and two year public educational institutions.

- Promoting registered apprenticeship training programs for paraprofessional occupations, building on DOL's current pilot project. This might include forums with the industry associations, business groups, and professional organizations and start-up grants.

- Developing and disseminating new and efficient methods of training direct care workers in long-term care settings, including use of distance and e-learning and train-the-trainer models, including exploring promising models of e-learning for personal care assistants.

- Encouraging professional schools of nursing to support undergraduate curriculum development around long-term care and geriatrics, as well as to expand the capacity of graduate programs in geriatrics and gerontological nursing.

- Cross-training current nursing assistants to work in long-term care settings.

- Promoting development and use of "soft skills" elements in training curriculum, to cover decision-making, problem-solving, communication, and teamwork for long-term care workers, to prepare caregivers who may be working independently with patients or being remotely supervised in home settings.

- Exploring with state and local adult education systems, as well as with employers, ways to expand English-as-a-Second Language training to long-term care employees who are limited-English proficient, to increase their effectiveness as well as job satisfaction.

- Provide incentives for licensed practical and licensed vocational nurses to prepare as professional registered nurses in order to work in long-term care settings following graduation.

- Target student support to undergraduate and graduate professional nursing students preparing to work in long-term care settings following graduation.

New Workers: Seek ways to broaden the supply of workers (e.g., encourage older workers, TANF recipients, other "non-traditional workers including family members and neighbors"). To tap new sources of workers, consider the following:

- Disseminating information on long-term health care careers through the Transition Assistance Program (TAP) for military personnel transitioning to civilian life.

- Encouraging state and local agencies, such as in the One-Stop and TANF systems, as well as training providers to use successful training models developed under DOL and HHS pilot and demonstration projects. This would include lessons learned from nursing-related H-1B skill training grants, WtW grants, and (HHS to add). Examples include the "retention and advancement" model being used with former TANF recipients, in which entry level workers are assisted in advancing into higher level jobs and the vacated jobs are backfilled with other job seekers.

- Creating incentives through targeted financial aid, particularly for students who enroll in undergraduate and graduate professional nursing programs and are willing to make a commitment to work in long-term care settings following graduation. This could include providing incentives for licensed practical and licensed vocational nurses to become registered nurses in order to work in long-term care settings.

- Encouraging with state and local K-12 educational systems to expand career awareness and training opportunities in high school for the long term care health care field. Worker Safety: Initiatives could involve: (a) Supporting continued education and outreach to employers on safety, such as through DOL's national emphasis program, and (b) Enhance worker safety training in current nurse and paraprofessional training and certification.

Worker Safety: Continue to support worker safety education and outreach to employers, such as through DOL's National Emphasis Program, and through enhanced safety training within schools of nursing and within the paraprofessional curriculum and training.

Support Informal Caregivers: Continue efforts to support informal caregivers, such as through tax incentives for caregivers, grants to state and local organizations (e.g. the National Caregiver Support Initiative), providing information and referral resources, and exploring the effectiveness of respite care demonstrations.